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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED SEP 5 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29677

Registration District No. 784 Primary Registration District No. 111 Registrar's No. 1567

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 6652 Clayton Road
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: St. Louis

(c) City or town: Richmond Heights
(If outside city or town limits, write "RURAL")

(d) Street No.: 6652 Clayton Rd.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Solomon Ure 600

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: M.

5. Color or race: W.

6. (a) Single, widowed, married, divorced: W.

6. (b) Name of husband or wife: Jane Ure

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased: Aug. 8, 1859 (Month) (Day) (Year)

8. AGE: Years 81 | Months 0 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace: St. Louis (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation: Retired Clerk

11. Industry or business: Western Union

FATHER
12. Name: William Ure 4
13. Birthplace: Scotland (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Margaret Mitchell
15. Birthplace: Scotland 4 (City, town, or county) (State or foreign country)

16. (a) Informant: Miss Mary A. Ure
(b) Address: 6652 Clayton Road

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-19-1940 (Month) (Day) (Year)
(c) Place: burial or cremation: Calvary

18. (a) Signature of funeral director: Arthur J. Donnelly
(b) Address: 3840 Lindell Blvd.

19. (a) AUG 15 1940 (Date received local registrar) (b) J. A. Meyer M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 15th. year 1940 hour 5 minute P. M.

21. I hereby certify that I attended the deceased from July 10, 1935, to Aug 15, 1940; that I last saw him alive on Aug 13, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Interstitial Nephritis	?
Chronic Myocarditis	?
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

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Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work?
(e) Means of injury

23. Signature: Frank J. Stange M.D. (M. D. ~~or other~~) 1
Address: 3943 Grand Blvd St Louis Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell Bl

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.